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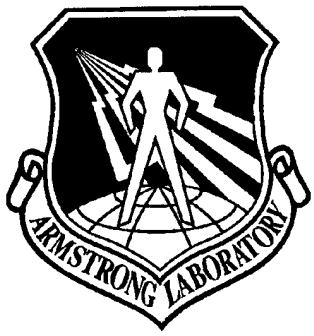

ARMSTRONG LABORATORY

MEDICAL PRISONERS OF WAR

THE REALITIES OF PRACTICING MEDICINE IN CAPTIVITY

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Final Technical Report

AIR FORCE MATERIEL COMMAND
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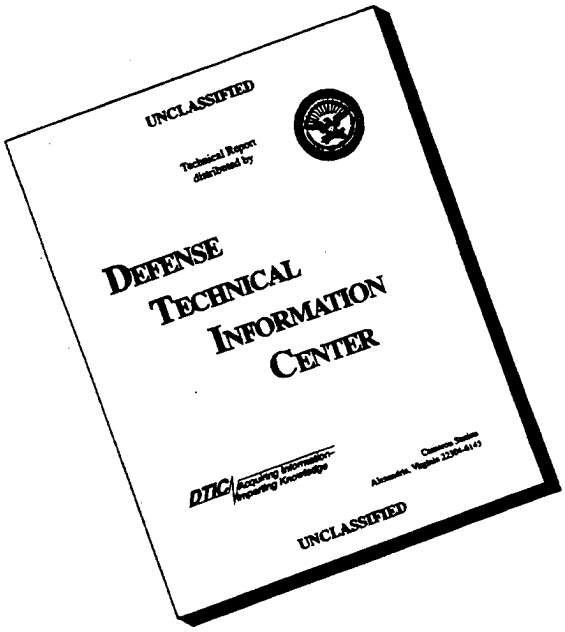

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The Office of Public Affairs has reviewed this technical report, and it is releasable to the National Technical Information Service, where it will be available to the general public, including foreign nationals.

The technical report has been reviewed and is approved for publication.

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American military forces are often deployed overseas on peacekeeping or humanitarian missions. The Gulf War demonstrated that international tensions may flare rapidly and United States military personnel could be involved in an armed conflict with little advance notice. As a consequence of their service in the Armed Forces, military physicians could be captured and interned as prisoners of war (POW), yet few consider this possibility. Lack of preparedness in the past has led to reduced survival rates among POWs. The medical prisoner who possesses a knowledge of military history will have a more realistic view of conditions and treatment to be expected while in captivity, and will be better prepared psychologically for his (or her) ordeal. These personnel should also be aware of their rights and legal responsibilities under the provisions of the Geneva accord. In previous wars the rights of captive physicians have been very different from the realities of their day-to-day existence. Medical personnel, by virtue of their special status under the Geneva Conventions, are granted certain latitude regarding the Code of Conduct, especially as it pertains to 1) the duty of the POW to escape, and 2) communications with captors. This flexibility is contingent on the captors' compliance with the provisions of the Geneva Conventions. The captive physician must keep faith with other prisoners and trust that the U.S. will be making every effort to secure his early release.

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Contents

On Life as a Prisoner of War...

"...It is a melancholy state. You are in the power of the enemy. You owe your life to his humanity, your daily bread to his compassion. You must obey his orders, await his pleasure, possess your soul in patience. The days are very long, hours crawl like paralytic centipedes. Moreover, the whole atmosphere of prison is odious. Companions quarrel about trifles and get the last pleasure from each other's society. You feel a constant humiliation in being fenced in by railing and wire, watched by armed men, and webbed about by a tangle of regulations and restrictions."

-- Winston Churchill

Introduction:

Capture and internment as a prisoner of war has been for some the most pathetic and miserable consequence of soldiering. The POW is neither a criminal nor a transgressor, but merely an unfortunate who has been defeated in battle. In the past prisoners have been an unwanted burden to the conquering force, however in recent years a POWs' capture may have been deliberately orchestrated to achieve political objectives. Ultimately, the POW is a hostage, a pawn to be used for bargaining purposes at the negotiating table.[13, 29]

The U.S.'s high position in world leadership has resulted in the deployment of American troops in an effort to combat aggression and restore political and social order. As tensions continue in Bosnia, Africa, Southwest Asia, Korea and elsewhere, the U.S. will likely remain a key player in peacekeeping and humanitarian missions around the globe. American armed forces personnel must anticipate and prepare for situations involving the potential of armed conflict.

Military physicians and other medical personnel can be placed far forward in the battle area which may result in personal injury or even death. Exposure to combat also increases the risk of capture and internment as a POW, but physicians rarely give thought to such a grim prospect. With the exception of those who are required to participate in survival and resistance training by virtue of their high risk status in certain military occupations, medical personnel receive a limited introduction to the Code of Conduct and the Geneva Conventions.[10] Most of those unlucky enough to be captured in a future conflict will be ill-prepared for the harsh realities of POW life. In past wars, a lack of preparedness has resulted in poor survival rates and increased vulnerability to exploitation. Military health workers must consider the possibility of capture and imprisonment by hostile forces where they may be misused, starved, tortured, or exploited for propaganda purposes.

Medics carry into battle certain items of equipment along with related technical skills which enable them to accomplish the

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military mission. Similarly, medical personnel should be offered training which will prepare them to survive a POW experience with their physical, mental and emotional health intact. They must be aware of their status, rights, and responsibilities under the Geneva Conventions of 1949. They should know and understand the standard of moral behavior expected of American POWs as stated in the Code of Conduct, and in what circumstances the Code of Conduct applies differently to medical personnel. In recent wars there has been a significant difference between a POW's rights under the Geneva Conventions and the reality of his day-to-day existence. Captive medical personnel who know about the experiences of former POWs will be better prepared to survive, resist, and return with honor.

This article will begin with a review of how POW treatment has evolved over the ages. It is important to gain an appreciation for the humanitarian and diplomatic efforts of past world leaders and how this has gradually improved the status of POWs. Given the fact that captured U.S. military personnel have rarely been treated in accordance with provisions of the Geneva Conventions, future captives must be mentally prepared to face harsh conditions. The experiences of former POWs will be related in the hope that the hardships and deprivations endured by some may stimulate thoughtful self-assessment as the reader considers how he or she might cope with a captive situation. Included are reports obtained from former medical POWs on the conditions of their captivity during WW II, Korea, and Vietnam. Medical personnel, by virtue of their special status under the Geneva Conventions, are granted certain latitude regarding the Code of Conduct.[10] The limits of this flexibility will be discussed.

Methods:

The literature was reviewed for information relating to POW camp conditions, military personnel in captivity, the Geneva Conventions, and the Code of Conduct. A specific search was accomplished looking for memoirs or anectodal reports from physicians and nurses who had been POWs. Many excellent accounts were located for the European and Pacific Theaters during World War II, the Korean Conflict, and the Vietnam War. The search yielded no reports by medical internees from the Civil War era or World War I, however several articles provided detailed descriptions of camp conditions and medical treatments of the day which were noteworthy.

The author visited the U.S. Air Force Survival School Library at Fairchild Air Force Base in Washington State. The library archives contain numerous reports from former POWs recounting their experiences in captivity. The library was also an excellent source for information concerning the Geneva Conventions and the Code of Conduct.

Statistical data on American POWs was obtained from the Department of Special Studies, Naval Aerospace and Operational Medical Institute in Pensacola, Florida.

Early history:

"Sometimes, when crimes have been committed it is necessary to go back and mark the spot."

-- Bill Young, former POW[9]

In antiquity primitive man and his barbarian descendants exterminated all captives. Survival at the subsistence level was difficult even during times of plenty, and captors were likely to view prisoners as additional mouths to feed and therefore better dead than alive. In primitive warfare a prime objective was the enemies head, scalp, or other bits of anatomy which demonstrated prowess as a warrior or enhanced virility. The institution of slavery and a more secure food supply only slightly modified this entirely primitive view.[2, 29]

In time the advantages of holding a captured headman or tribal chief as hostage became apparent, but as a rule the vanquished of the ancient world faced annihilation. The Greeks executed those prisoners that were of no use to them and sold the rest into slavery. In 400 B.C. (Before Christ) Plato expressed the view that the soldier who gives up fighting deserves whatever happens to him as a prisoner. In 352 B.C. when Alexander the Great defeated the Phokians at Krokos and found that he had captured 3000 men he did not want, he drowned them all. Two thousand years later the Soviets used a similar method to rid themselves of 7000 Polish officers they held as POWs. The prisoners were put on barges, towed out to the middle of the White Sea, and abandoned with the seacocks open.[29]

In 200 B.C. humane treatment of captives found an advocate in India with the Code of Manu. The Hindu warrior was instructed to do no injury to the defenseless or to a subdued enemy.[26] Sun Tzu and Tamerlane felt that captives had their uses, and it was better to capture soldiers than kill them outright. Prisoners could be enslaved and made to perform work that was repugnant to the captors.[2]

Early religions sometimes used captives for ritual slaughter as part of the victory celebrations. Roman legionaires were burned alive at the foot of the Teuton altars after the decisive defeat of Varus in 9 A.D. (Anno Domini) Following a period of public display some prominent captives, like Vercingetorix, the Gallic commander taken at the siege of Alesia, were strangled in full view of the vanquished troops and the rest were sold into slavery.[29] The Romans used their captives for target practice or as gladiators. Others were tortured for public amusement. Captured warriors rowed Caesar's galleys and were killed when they could no longer pull an oar.[2]

During the latter years of the Roman Empire the position of the captive improved. The spread of Christian doctines of brotherhood and equality brought better conditions for prisoners, and the killing of Roman slaves was outlawed.[2]

Mutilation was employed in earlier times to neutralize captured soldiers. After one naval battle the Athenians cut off the right hand of each of the enemy rowers they captured, thus depriving the opposing fleet of its crews without actually killing them.[29] One Greek emperor is said to have blinded 15,000 Bulgarians before sending them home. King Wau, a 'just king' who ruled in B.C. China, had the commanders of captured forces put to death, but released the rank and file after each had one ear sliced off.[29] When Richard Coeur de Lion captured 15 enemy knights in 1198, he blinded all but one. The latter was spared an eye in order to lead his companions back to the French army, which was considered an act of clemency at the time.[29]

During the dark ages the captured soldier continued to face execution or enslavement. Many preferred to fight on and risk death rather than surrender. Chivalry developed with the rise of Christendom. The true knight refused to slaughter his conquered foe, rather, he chose to be merciful to a gallant opponent.[26] In 1179 A.D. the Third Lateran Council decreed that Christian POWs should no longer be sold into slavery. This decree inadvertently promoted the killing of POWs since captives no longer had value to the conqueror as slaves. The Thirty Years War provides several examples of wholesale slaughter of prisoners: Heidelberg, Magdeburg, Kempten, and others.[29] The advocates of humane treatment for prisoners gained voice in Hugo Grotius, a Dutch lawyer, humanist, and a renowned democratic thinker. A former POW himself, Grotius devised a set of rules for the treatment of prisoners. Although his efforts were not immediately successful, he managed to publicize the problem of prisoners of war.[2]

In 1637 the French writer Gabriel Naude` put forward the suggestion that those who surrender but cannot pay a ransom need not be put to death. In 1758 the French humanitarian Vattel expressed the view, "As soon as your enemy has laid down his arms and surrendered his body, you no longer have any right over his life." This position gradually gained acceptance in the West so that a soldier who surrendered to the enemy might reasonably expect humane treatment.[29]

In Europe during the 17th century the concept emerged that prisoners of war were the custody of the capturing sovereign or state, not the field commander. The prisoner was protected from servitude and personal revenge. Later, captivity was considered a means of preventing return to friendly forces. Military prisoners were no longer considered guilty of crimes against the state.[26]

In 1785 Prussia and the United States signed a Treaty of Friendship which contained many of the provisions of the later Hague Regulations, such as, that prisoners should not be confined in civil convict prisons nor fettered. They were to have rations on the same scale as the captors' own troops.[29]

During the American Revolution the United States established the death penalty for those prisoners who, after capture, took up arms in the service of the enemy. Duress or coercion was recognized as mitigating only in the event of threatened immediate death. This was the first American definition of required prisoner conduct. On

3 July 1863 the U.S. War Department issued General Order No. 207. The order mentioned that it is the duty of a prisoner to escape. This order apparently addressed the widespread practice of surrender and subsequent parole to evade further service as a combatant.[26]

The harsh conditions which prevailed in the American POW camps during the Civil War gained widespread notoriety.[4] The resultant public furor prompted President Lincoln to ask Francis Lieber, Professor of History and Law at Columbia College in New York to draft a code of war governing the Army's conduct in the field. Lieber was an experienced soldier, and the document he authored, "Instructions for the Government of Armies of the United States", profoundly influenced future diplomatic efforts to promulgate the rules of modern warfare.[2] Some old ideas regarding POW treatment persisted in spite of this progress. For example, the Lieber document repeated the traditional view that in an emergency a commander was at liberty to kill his prisoners.[29]

Prisoners of war were again considered in 1874 by a conference in Brussels and a code was constructed based on many of Lieber's original stipulations. Although it was not ratified, the code set the stage for the first Hague Conference of 1899 where disarmament proposals, POWs, and other issues were discussed. Eight years later in 1907 a second Hague conference served to reaffirm the principles set forth in 1899, and these were the rules of war in effect at the beginning of WW I. During the war a number of agreements relating to the treatment of POWs were concluded, and these agreements had considerable effect on future efforts to develop rules of war concerning POWs. In 1929 the delegates of 38 nations (not Soviet Russia) assembled in Geneva to frame a treaty which could supersede the Hague conferences. It was decided that the provisions of the 1929 Geneva Convention should be binding regardless of whether it was ratified by all the belligerents in a war.[2]

In 1945 the concept of war crimes was accepted by the international community via the Nuremburg Trials. A key principle of the Trials, that a soldier who was obeying orders is not exonerated if he commits an atrocity, gained international support.[29]

Shocked by the number of prisoners who died in captivity during WW II, delegates met at Geneva in 1949 to formulate and define higher standards of treatment for POWs. The articles of the 1929 Geneva convention were clarified and strengthened. Fifty-seven nations signed the new Geneva Treaty. The Soviet Union and eight other Communist bloc countries also signed, with reservations to Articles 10, 12, and 85. Article 10 states that an organization may not assume the functions of a Protecting Power without the consent of the state of the POW. Article 12 states that in case of transfer of a POW by the Detaining Power to another power, the Detaining Power is responsible for the treatment of the POW. Article 85 applies the Convention to POWs who have been convicted of war crimes under the Detaining Power.[26, 36]

In 1952 The United Nations (U.N.) Command recognized that a POW can still be 'an active soldier determined to fight on', implying that surrender is not necessarily an offer of peace. The U.N. also

recognized that POWs can have the right not to be repatriated if they do not wish to go home. In 1953 U.S. Order 207 restated the position that a soldier taken prisoner is duty bound to try to escape.[29] In 1955, the U.S. Department of Defense developed and began training servicemen in the Code of Conduct.

American Civil War:

"Every captured wounded man shall be medically treated according to the ability of the medical staff."

-- Francis Lieber (1863)[2]

International agreements governing the rules of modern warfare have greatly improved the plight of the modern prisoner of war. These improvements are more fully appreciated when examined in light of prison conditions known to exist during the American Civil War. An accurate historical perspective will serve as a useful yardstick to measure how far we have come.

Much has been written about the Civil War and the harsh conditions which prevailed in the prison camps on both sides. Although Andersonville Prison in Southwest Georgia was the site of the most deaths in any prison camp of the Union or Confederacy during the war, the percentage of deaths to total prisoners (26%) was matched by Northern prisons. The camp for Confederate prisoners at Elmira, New York serves as an example where, in one winter, 3000 out of 12000 captives perished. Less known but equally pestilent northern prison camps included Camp Chase in Columbus, Ohio and the Delaware River Island camps.[2, 4]

From the time Andersonville Prison opened in November 1861 until it closed in April 1865, 52,345 Union prisoners were sent to the camp. Of these, 13,783 captives died and were buried at Andersonville. During a four month period from June 30 to October 30, 1864, 10,000 perished. The majority of the men died as a result of overcrowding and exposure to the elements which led to dysentery, exhaustion, malnutrition, scurvy, smallpox, pneumonia and hospital gangrene.[4, 40]

Dr. Joseph Jones, 1856 graduate of the University of Pennsylvania Medical School, served as a medical inspector for the Confederacy. He was present at Andersonville Prison in August and September 1864, staying there for several weeks. The following is an excerpt from his report to the Confederate Surgeon-General concerning Andersonville:[4]

1. Sweet Water Creek, a source of water for prisoners, was contaminated by human excrement and other filth. It contained maggots, animaliculae, and cryptogenous plants.

2. Fleas flourished in the sandy soil and mosquitoes swarmed in great numbers.

3. There were 9,479 deaths (30%) among the entire number of prisoners from February to September 1864.

4. A horrible stench arose from the combination of human dung and filth covering the low grounds of the camp. The diseases most prevalent were acute diarrhea and chronic dysentery.

5. Human skeletons cried out for food and medical attention in the prison hospital; flies swarmed down their open mouths and lice crawled over their clothes. Men brought into the hospital from the stockade were so begrimed from head to toe in their excrement and so black from smoke and filth that they resembled Negroes rather than white men in appearance. Men preferred to die by slow starvation rather than eat the husk-corn meal and die an agonizing death from lacerated intestines.

Dr. Jones's report in September of 1864 described Andersonville as a "great mass of misery". It was sent to Confederate Commissioner Alexander Stevens who then gave the report to Jefferson Davis. No action was taken on the matter.[4]

The unspeakable horrors and high death count at Andersonville Prison were well known during the war. The prison gained further notoriety in 1865 with widely publicized accounts of the trial and hanging of Henry Wirz, M.D. Dr. Wirz, who was actually fourth in command at the prison, was a dedicated professional soldier. He expressed concern for the prisoners and made efforts to improve conditions inside the stockade, but was thwarted by higher-ranking prison officials. Dr. Wirz was the only Confederate officer brought to trial for what occurred at Andersonville, a topic of heated debate in 1865 and a controversy that persists to this day.[4]

World War I:

"We live in a kingdom of thorns...it is like a man pointing a revolver at you, in such a way that wherever you look you stare down the muzzle..."

-- French POW in WW I[2]

World War I, the 'Great' war, saw the advent of new doctrines utilizing scientific intelligence, psychological operations, and propaganda. Gentlemanly conduct and humanitarian concerns were secondary to the war effort. The Germans first attempted the use of political indoctrination in 1914, and though it was not particularly successful, it set a precedent for future conflicts.[26]

As the war progressed food became scarce and prison fare declined in quality and quantity until what little remained for the prisoners was barely edible. By 1917 prisoners in the German camps depended on supplementary supplies for much of their diet. Conditions in the

British camps housing German POWs were no better. In 1917 a visitor to one German POW camp found 600-700 men suffering from severe malnutrition. The observer noted that the captives were too exhausted by hunger to move from their cots, and that prisoners yielded to the ravages of disease and starvation at the rate of 10-40 per day.[2]

When prisoners were quartered in large numbers the civilian population was further deprived to look after the POWs. Local doctors were conscripted to provide medical care for captives. At times these doctors were unable to cope with the mass of patients charged to their care, many of whom they could not understand. The inevitable result was frustration and exhaustion, leading to indifference on the part of some medical personnel. This also led to deplorable actions by a few physicians who allowed an epidemic to spread and so rid themselves of a burden. In isolated cases diseases were deliberately spread by having the infected patients transferred from one camp to another (this occurred in Russia and Rumania).[8, 29]

POW life was easier for many American prisoners than for captives from other Allied countries. Americans were late entrants into the war and German leaders recognized the significance of U.S. involvement in the conflict. It is probable that American POWs were treated leniently as a matter of expediency during the final months of the war.[26, 27] Regardless of any favorable treatment they may have received, 147 of the 4120 Americans captured during WW I died in captivity (3.6%).[35]

World War II; European Theater:

"For me, the toughest part of the war was just beginning. I was on the verge of a unique medical experience. Less than a half hour after the 'war was over for me', I was applying a splint to my copilot's broken leg and my new job had begun."

-- Leslie Caplan, M.D.[3]

The totality of WW II introduced massive aerial bombardment of military formations and civilian targets, land and sea battles of unprecedented scale, crude but effective military rocketry which terrorized a nation, and the first use of atomic weapons. New terms were coined to describe these events--genocide, death march, mass destruction--and obscure place names gained infamy--Bataan, Auschwitz, Malmedy, Hiroshima, et al.[34]

The dimensions of the POW experience during World War II are immense. More than 10 million servicemen, and a much smaller number of women, spent some portion of the war in a POW camp. The experiences of medical officers was often quite different when compared to other officers in captivity. Medical personnel were usually allowed to practice their profession whereas infantry officers, engineers and pilots obviously did not utilize those skills after capture. The opportunity to practice medicine was a

relief from the enforced idleness which plagued the non-medical POWs. It also created major dilemmas for the medical officers, particularly with respect to escape. Technically, medical officers were protected personnel under the provisions of the Geneva Conventions of 1929 and repatriation should have been automatic, but the majority were denied this privilege. Was it then the medical officers duty to escape, and if so who would care for the sick in the camp? If medical officers escaped would sanctions be taken against other medical personnel which might prevent them from providing care to the POWs?[31]

Medical facilities were often used to facilitate escape or for the transportation of illegal materials. Small tools, money, papers, and other contraband were regularly concealed inside bandages, casts, and the padding of crutches. In Java, a radio was fabricated with parts shaped like medical instruments. In a camp in Germany a crystal set was wrapped in the bandages of a man suffering from phlebitis when a snap inspection occurred. The medical officer was faced with a choice. Which was more important, a duty to move illegal items, gather intelligence, and support clandestine activities, or the medical responsibility not to jeopardize the repatriation of the blind, amputees, and the tuberculous? Some medical officers decided to support undercover operations while others chose to distance themselves from such activities. Captive physicians in past wars quickly realized that military duty does not always conform with the ethics of medical practice.[31]

There were 95,532 Americans captured in the European Theater during WW II. Conditions in camps throughout Europe varied considerably. On the one hand there were the "show" camps, used by the Germans to impress visiting Red Cross officials. These camps often housed downed aircrew, who were treated with respect by the Germans because of their admiration for aviation.[27] They often contained well equipped medical and dental facilities with supplies provided by the Red Cross.[25] Frequently there were educational and recreational services such as libraries, craft shops, organized sports, clubs and theatrical groups. Political indoctrination was notably absent from these camps.[27]

The Stalags housing the average American POW lacked such amenities, and most camps did not abide by even minimum standards for POW treatment. The usual POW camp ration consisted of sawdust laced black bread, heavy sausage and potato soup, a diet which did little to prevent chronic malnutrition.[27] The inadequate diet combined with heavy labor and limited medical care was a source of great misery for the POWs. Virtually all POWs claimed to need medical treatment at some time during their internment. The main complaints were muscle and joint pains, colds, coughs, weakness, loss of weight, and nutritional disorders relating to vitamin deficiencies, such as bleeding gums, hemorrhages and diarrhea. Many received no help until they became acutely ill. As one might expect, epidemics such as typhus and tuberculosis were a constant threat.[6, 16, 23]

The greatest suffering for European Theater POWs occurred during transfers between camps. As the German controlled territories shrank in the latter stages of the war many prisoners were force

marched in winter conditions to escape the advancing Red Army. One American POW physician relates how the men in his camp were marched for 86 days in severe weather for a total of over 500 miles. There were many atrocities along the way.[3] By the end of the war in Europe some repatriated American POWs were mere skeletons, resembling victims of the Nazi concentration camps. Nevertheless, the mortality rates among European Theater POWs were far lower than in the Pacific Theater. Of the 95,532 American POWs captured by the Germans 1,124 (1%) died in captivity, compared to 40% of those held by the Japanese.[27, 35]

World War II; Pacific Theater:

"You are only a few remaining skeletons after the invasion of East Asia for the past few centuries, and are pitiful victims. We will build the railroad if we have to build it over the white man's body. If you want anything, you will have to come through me...and there will be many of you who will not see your homes again. Work cheerfully at my command."

-- Lt. Col. Y. Nagatomo, Chief, No. 3 Branch Thailand POW Administration. 1943.[38]

There were 27,465 U.S. military servicemembers reportedly captured by the Japanese as a result of the Bataan campaign, the fall of Corregidor and Pacific Islands, and other military actions in the Pacific. These men were principally held in camps in the Philippines, Japan, and Manchuria. The Pacific Theater POWs suffered the greatest hardships of any group of American POWs. Forty percent (11,107) of the Americans captured in the Pacific died prior to repatriation.[27, 35]

The Japanese considered surrender to be military immorality. Their system of discipline, enforced by frequent beatings, plus the language barrier, led to much brutality toward the captives. At least 90% of Pacific POWs received some form of direct physical punishment from their captors. Very few escaped at least one beating during their internment.[19, 27]

As in Europe, some of the worst physical deprivation occurred while prisoners were being transferred to the various camps. After the surrender at Bataan, the captured troops were marched to Camp O'Donnell, a 100 mile, two week "Death March" essentially without food or water, in which about 17,000 American and Filipino men died. The severity of the "March" depended to a great extent on the mood of the Japanese guards. One section of prisoners might be in reasonably good shape while another group a mile or two behind suffered terribly at the hands of their captors. Stragglers were bludgeoned, bayoneted or shot.

During the days and weeks following Pearl Harbor there were many atrocities. Two hundred British wounded were murdered by the Japanese Imperial Guards on the banks of the Muar river in Malaya. General Percival related another situation at the fall of Singapore:

"The Japanese troops entered the great military hospital at Alexandra Park and there a tragedy took place. They claimed Indian troops had fired from the hospital. Whether they did so or not, I cannot say. As a reprisal they (the Japanese troops) bayoneted some members of the staff and patients including one poor fellow as he lay on the operating table. There were many horrors in the last war but for cold-blooded barbarity this deed will surely rank very high."[2]

Manpower shortages in critical industries led the Japanese in late 1942 and early 1943 to ship prisoners to Japan or China. These transports were overcrowded, filthy, and vermin infested. Prisoners were jammed into the holds with no provisions for exercise, fresh air, or normal body functions. Food was thrown down to the prisoners, and though many had diarrhea or dysentery, there was little water. Many deaths resulted from these conditions. Some who would have survived were drowned when a few of these transport ships were mistakenly sunk by American bombers and submarines.[20, 27]

The Bataan-Corregidor POWs were initially interned at Camps O'Donnell, Cabanatuan, Bilibid prison, Palawan, and Davao. Slave labor coupled with severe shortages of food, water, and medical supplies resulted in the deaths of approximately 1500 of the 8000 Americans at O'Donnell during the first six months of captivity. At Cabanatuan 2700 out of 6500 died during the first year of internment.[27]

Conditions were little better for the American nurses and civilians taken at the capture of Manila and Corregidor. Dietary deficiencies and starvation took a heavy toll, and burial details were delayed until an internee could be found who was strong enough to dig graves. Rations decreased until January 1945 when the daily issue was 600 to 700 calories a day. The standard issue was rice and corn with no meat or other protein source. Adults in the camp further divided their rations with the children to improve their meager intake. By December 1944 up to 90% of the adults had famine edema. New cases of tuberculosis were rising sharply, and epidemics of measles, whooping cough, and bacillary dysentery began to appear with a corresponding rise in the death rate.[21]

Amidst the brutality and deprivation in the Japanese POW camps, some medical personnel were conspicuously heroic:

"No one who was at Zentsuji as a prisoner of war will forget Lieutenant Commander H.J. Van Peenen. We had several medical doctors in the prison camp but Commander Van Peenen was the only one who attempted to practice his profession. He was able to get some medicine from the Japanese, and maintained a sick bay for the worst cases. He performed several operations on people who would have died in other camps. He was the most respected man in the camp. The Japanese also held him in high esteem."[14]

Many thought that Dr. Henri Hekking, a Dutch physician interned on the Burma-Thai railroad, was sent by God. His methods of treatment, derived from years of service in the tropics, went far beyond those

of his medical contemporaries in other camps. One American sailor wrote:

"I always marveled at the record that our group had in the Burma jungles. We lost thirteen men all the time Doc Hekking was with us. He did not perform a single amputation. All the while in the other camps, men were dying at a much higher rate, and many amputations were being performed."[37]

Many survivors of the Burma death camp insist that Dr. Hekking's success went beyond his knowledge of the jungle and tropical diseases. He became known for his 'presence'. Usually, when visiting a patient deep in the jungles, he would sit beside the soldier and engage him in conversation. Then he would touch the patient, placing his hand on the man's brow, and the man would feel better. Many who were close to Dr. Hekking were convinced that "he had special powers unknown to us."[9, 38]

Sanitation was always a serious problem in the camps. Flies were everywhere, and maggots thrived in the latrines. Many prisoners were too weak from dysentery to reach the latrines, soiling their sleeping mats and the barracks grounds. Boiling clothing finally brought the lice problems under control.[20]

Vitamin deficiency diseases were the inevitable consequence of the poor diet which consisted mainly of polished rice. The rice was invariably dirty, moldy, and filled with maggots, weevils, and sometimes rocks or even broken glass. Pellagra was rampant, as were the wet and dry forms of beri-beri. Tropical ulcers became a common problem. Any superficial abrasion, nick, or cut would break down to form a reeking necrotic ulcer that could only be treated with curettage and what crude bandages were available. Tropical ulcers were ubiquitous among the prisoners, exquisitely painful, and the source of much morbidity and mortality. Gradually the prisoners became stabilized at a level of health not uncommon in the oriental villager or coolie.[28, 32]

In addition to the forced labor, injury, and Japanese brutality other causes of morbidity included the tropical heat, malaria, dengue fever, scrub typhus, diptheria, and cholera.[33, 38] Sick call was an endless parade of skeletonized patients lined up in front of the dispensary hoping for miracles. Most of the therapy had to be improvised since there was very little medicine. Medical supplies for POWs were totally inadequate. A typical issue for 1000 men consisted of 6-12 bandages, one 2 oz. bottle of iodine and a few unidentified tablets.[5, 12] Improvisation was the order of the day and every scrap of material, whether nail, wire, leather, old tins, or fabric had to be utilized. Surgical retractors were made from Dutch mess kits. In one camp a suction apparatus was made from an old Ovaltine tin, a few stolen springs, and a wooden plunger covered with hide. Anesthesia was a particular problem. Small amounts of Procaine were careful conserved and used for spinal anesthesia when abdominal surgery or lower limb amputations were necessary. When available, intraperitoneal sulfanilamide was used in abdominal surgery with favorable results. Suture material was improvised using cotton thread or silk parachute cord.[17, 20, 39]

A typical day for the camp medical officer began with sick call by the light of an oil lamp. The sick were paraded before the Japanese camp commander. Each man's case was described, and the medical officer argued to keep the sickest men out of the labor details. The medical officer was beaten if the daily quotas of men fit for work were not met. After this he made rounds in the camp hospital dispensing what he had, mostly sympathy and a kind word. When men returned to camp after dark another sick call was held. The medical officer was also expected to help dig graves. Everyone suffered from deficiency diseases, and most had malaria and dysentery. Few had adequate clothing and many went without footwear. For this reason the effects of the dead were redistributed among the living. Great ingenuity overcame some of the equipment and supply shortages. Soap was manufactured using available oils, fats, and wood ash. Alcohol was distilled from native bootleg liquor for use in surgery and to sterilize syringes. In Burma a Dutch chemist produced emetine from ipecacuanha which was pure enough for injection, producing dramatic results in the treatment of amebiasis. Eye disease was common due to Vitamin A deficiency. At Nakom Paton, an ingenious ophthalmoscope was constructed using a coconut oil lamp, parts of a Rolls razor, a metal concave mirror and some lenses. Intravenous solutions were made with rock salt dissolved in strained and boiled rain or river water. An empty Japanese wine or beer bottle served as a container. This was connected to stethoscope tubing and a cannula carved from a piece of bamboo. By this method IV infusions were administered and complications were surprisingly rare.[11, 12] Often the Japanese had no medical services nearby and would visit the POW physicians. If one of the guards needed to have a tooth extracted, the medical officer would protest that he had no cocaine. When the Japanese soldier procured some, the doctor filled the syringe with water, removed the tooth, and added the drug to his small cache of medicines.[15] Reports of the inventive methods used by POW medical personnel to make medicines, instruments, and prostheses would fill volumes.

Korean War:

"Up to this time your education has been incomplete. You have only learned how to cure. We Communists will teach you whom to cure."

-- Indoctrination training for an American Medical POW[1]

The period of Korean captivity has been divided into three general phases. The first phase started with capture, continued with assignment to temporary camps, and ended with arrival in a permanent camp. Roughly the time frame was from July 1950 to February 1951. This phase of captivity was characterized by lack of food and shelter, forced marches, and exposure to the elements without adequate clothing. Oftentimes potable water was not available and prisoners were forced to drink from polluted sources such as open cisterns, creeks, and rice paddies. The vast majority marched to rear areas, carrying the wounded on improvised litters or on their backs. Medical treatment was limited to first aid with improvised

splints and rag dressings. Severe mental depression was extremely common.[1]

The Korean War had its own "Death Marches." On one of these marches in the winter of 1950-51, 700 men were headed north. The trails were knee deep in snow and arctic conditions prevailed. When the camp was finally reached, 500 had perished. In the "Sunchon Tunnel Massacre" a train carrying POWs bound for Manchuria was halted in a tunnel and set on fire by the North Koreans. The prisoners were burned alive and others who had been taken off the train were machine-gunned.[27]

Permanent camps were set up after the armistice negotiations had begun to make progress in the spring of 1951. Physical and psychological abuse continued at about the same intensity as the first phase of captivity. The men were housed in unheated Korean farm houses. Sanitation and personal hygiene were extremely poor and medical care was inadequate. By the spring of 1951 the prisoners were resorting to boiling and eating weeds which grew adjacent to the prison compound. Pneumonia and dysentery were epidemic. Some of the captured medical personnel were allowed to see patients, however medical and surgical supplies were extremely scarce.[37]

American and British POW physicians provided medical services to captive personnel until the spring of 1951 when these activities were forbidden. They were replaced by marginally trained Chinese attendants with only rudimentary medical skills. The average Chinese physician would elicit the chief complaint and then prescribed medicine for symptomatic relief. Only one symptom was treated at a time. An especially popular remedy consisted of the subcutaneous transplant of small pieces of chicken liver that had been bathed in a weak solution of penicillin. This was touted as a great panacea developed by Soviet scientists. While the possibility of infection from the treatment was great, many malnourished POWs volunteered for the procedure because it was accompanied by an increased food ration. The implant either calcified or sloughed through the operative site, but the patients overall health generally improved with the increase in diet. Acupuncture was also a common remedy for headaches and other chronic discomforts, yielding mixed results.[1, 27]

The third period of captivity began in October 1951 with gradually increasing quantities of food, clothing and medicine. Housing became relatively comfortable and clothing was sufficient for survival. Medical care was never adequate, and vitamin deficiency diseases were prevalent.[1]

All personnel were subjected to an intensive indoctrination program which began on the day of capture. This is the major characteristic that distinguishes the Korean War POW experience from previous wars. The indoctrination program was accomplished by first breaking down organized and individual resistance. The prisoners were kept cold, hungry, and in a state of physical and mental exhaustion. Gradually they realized that continued resistance would mean starvation and death. As the resistance softened the POWs entered a period of

intensive formal study. Food and clothing were improved so long as the prisoners were 'making progress'. Formal studies eventually stopped and individual and small group interviews were conducted to determine points of individual susceptibility in the areas of race, religion, or socio-economic status. The indoctrination served two purposes: first, to select and convert susceptible prisoners, and second, group neutralization. Very few prisoners accepted the Communist ideology (21 refused repatriation at war's end), however the Communists attained some success in fostering distrust and discontent within the groups of prisoners. [1, 37]

During the Korean War 7,140 Americans were captured. Thirty seven percent (2,701) died in captivity.[35]

The Vietnam War:

"We craved food; we dreamed of it; we fantasized; we constructed elaborate menus; we deliberately created food-oriented conversations; we smelled food; we thought food; we lived food. And in the end we died for want of it."

-- Floyd H. Kushner, M.D.
Vietnam POW[22]

From the introduction of American forces into Southeast Asia in March 1964 through January 1973, 1,916 men were listed as captured or missing in action. Seven hundred seventy two were confirmed to be POWs held in camps primarily in North Vietnam. The duration of confinement lasted a few weeks to eight years, with the average length of captivity being five years.[24]

The Vietnamese believe that life on earth is only a short interlude. Death opens the door to a higher existence and should not be feared. This belief system colors the Vietnamese view toward POWs with much of the ill-treatment due simply to neglect. American POWs captured by Viet Cong guerrilla forces in South Vietnam were held in small groups. Many were continuously on the move in an effort to avoid ground and air attacks. While they may have been subjected to less torture and fewer interrogations than their comrades in the north, they were faced with the more compelling, immediate problems of daily survival. Starvation was only averted by eating anything offered, plus whatever they could catch or scrounge in the jungle. After six months the average prisoner had lost 40 to 50% of his body weight.[2, 27]

POWs held captive in North Vietnam had somewhat better living conditions, especially after 1969 as the Paris peace talks got underway. As a result, the mortality rate for prisoners held in North Vietnam was much lower than for captives held in the south. POWs were quartered in prisons offering better protection from environmental trauma. The prison diet usually consisted of a half loaf of bread, or rice, with vegetables or pumpkin soup. In one camp the normal fare consisted of six months of pumpkin soup followed by four months of cabbage soup, and then two months of

turnip green soup. Sometimes there was a side dish consisting of sauteed pumpkin and pig fat, or a serving of bean curd or fish powder. Although the camp officials were careful to boil all drinking water, poor sanitary conditions caused intestinal worms and other parasitic diseases. An adequate immunization program prevented communicable diseases such as cholera and typhoid.[13, 27]

Medical care in the North Vietnamese camps was provided by 'assistant doctors' (Vietnamese medics) and they had only basic equipment such as tweezers, razor blades, cotton, and bandages. The availability of treatment was unpredictable, and was always influenced by political considerations. The seriously ill POWs were examined by North Vietnamese physicians, a few of whom appeared to be well-trained and knowledgable. Withholding medical care was a tool used to obtain information and propaganda from POWs. Dental care was extremely rare. Some captives had their teeth pulled after two years of pain. In a few isolated instances, men actually considered collaboration with the captors in exchange for treatment and relief from tooth pain.[24, 25]

Dr. Floyd H. Kushner was the only U.S. military physician captured and interned during the Vietnam War. A U.S. Army physician, Dr. Kushner's helicopter was shot down on 30 November 1967 and he was held captive by the Viet Cong for three years before being marched to North vietnam early in 1971. In South Vietnam he was held in a small camp with 26 other American soldiers. Five were released as a propaganda gesture by the Viet Cong. Of the remaining 22, one was executed by the Viet Cong and nine more succumbed to the rigors of prison life, a mortality rate of 45%.[22]

When he was shot down Dr. Kushner suffered a broken wrist, two fractured ribs and a bullet wound in his left shoulder. Two aspirin tablets were his only anesthetic when the bullet was removed. There were no antibiotics or bandages. Later in the POW camp he developed a kidney stone, which he passed spontaneously. "For four days I laid on my bed and cried," he said. During his internment Dr. Kushner was forbidden to care for his fellow POWs. He maintained a clandestine practice using the primitive materials available, such as banana leaves and vines for bandages, and mud and bamboo for casts and splints. One man suffered a myocardial infarction with cardiac arrest. Dr. Kushner was able to successfully resuscitate the patient, who survived his ordeal and eventually returned to the United States.[22]

The diet was rice. It was rotten, sandy, and contaminated, full of rat feces and weevils. Once a month the 13 surviving prisoners received one 15 ounce can of sardines to divide amongst themselves. They ate maniok, a local root, and received 20 to 30 grams of pork fat per month. Malnutrition and vitamin deficiency diseases were universal.[30]

Dr. Kushner related three rules to stay alive. Number one, eat anything that is available. It doesn't matter if it's rice, rats, snakes, or roots. Number two, stay as clean as possible. Malnutrition severely diminishes cold tolerance, and bathing in icy water may be excrutiating, but it must be endured. Number three,

keep active mentally and physically. Despite illness, weakness, and lack of shoes, prisoners were required to work in the rice fields. They chopped wood, dug roots and carried heavy loads for miles over mountain trails. After a day of back-breaking labor, mental activity required great effort. In surviving the many hardships and deprivations of captivity, Dr. Kushner felt that mental strength was infinitely more important than physical strength. Those with strong family or religious ties survived and functioned more efficiently.[22, 30]

Seven hundred seventy two military personnel were captured and interned during the Vietnam conflict. One hundred fourteen (14%) died in captivity.[35]

The Geneva Conventions of 1949:

Fifty-seven nations signed the provisions of the Geneva Conventions of 1949. Articles of special significance to physicians in captivity are described briefly below.[27, 36]

Geneva Convention Relative to the Treatment of Prisoners of War of August 12 1949.

Article 13 -- POWs must be treated humanely and protected. Reprisals against POWs are prohibited.

Article 21 -- POWs are not to be held in close confinement.

Article 26 -- Sufficient food is to be provided, loss of weight is to be prevented, and account is to be taken of the normal diet.

Article 30 -- Adequate medical care is to be provided

Article 109 - Seriously sick and wounded are to be repatriated immediately, and those POWs long in captivity are to be released.

Article 120 - Full information is to be provided on deaths in captivity, including circumstances, cause, burial and grave identification.

Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field of August 12, 1949.

Article 12 -- The sick or wounded shall be treated humanely. They shall not be murdered or exterminated, subjected to torture or to biological experiments. They shall not be willfully left without medical assistance and care, nor shall conditions exposing them to contagion or infection be created.

Article 24 -- Medical personnel shall be respected and protected in all circumstances.

Article 25 -- Hospital orderlies, nurses, or auxiliary stretcher-bearers shall likewise be respected if they are carrying out their duties when they fall into enemy hands.

Article 28 -- Medical personnel designated in Article 24 shall be retained only in so far as the state of health of the prisoners require, and they shall continue to carry out their medical duties on behalf of prisoners of war. They shall be authorized to visit periodically the prisoners of war in labour units or hospitals outside the camp, and the detaining power shall put at their disposal the means of transportation required. Medical personnel shall not be required to perform any work outside their medical duties.

Article 29 -- Personnel designated in Article 25 shall be designated prisoners of war, but shall be employed in their medical duties as the need arises.

Article 30 -- Personnel whose retention is not indispensible by virtue of the provisions of Article 28 shall be returned to friendly forces as soon as a road is open for their return and military requirements permit. Pending their return they shall not be deemed prisoners of war.

The Code of Conduct:

Medical personnel are granted, by virtue of their special retained status under the Geneva Conventions certain latitude under the Code of Conduct. That flexibility is directly related to the policies of the captors as to whether they adhere to the requirements of the Geneva Conventions to let medical personnel perform their professional duties. All medical personnel should understand the limits of this flexibility.[10, 13]

Article I:

"I am an American, fighting in the forces which guard my country and our way of life. I am prepared to give my life in their defense."

Comment: No additional flexibility.

Article II:

"I will never surrender of my own free will. If in command, I will never surrender the members of my command while they still have the means to resist."

Comment: No additional flexibility.

Article III:

"If I am captured I will continue to resist by all means available. I will make every effort to escape and aid others to escape. I will accept neither parole nor special favors from the enemy."

Comment: a). Under the Geneva Conventions medical personnel who fall into the hands of the enemy are entitled to be considered retained personnel and are not to be considered POWs. The enemy is required to allow such persons to continue to perform their medical duties, preferably for POWs of their own country.

b). Medical personnel who fall into the hands of the enemy must assert their rights as retained personnel to perform their medical duties for the benefit of the POWs and must take every opportunity to do so.

c). If the captor permits medical personnel to perform their professional duties for the welfare of the POW community, special latitude is authorized those personnel under the Code of Conduct (Executive Order 10631) as it applies to escape.

d). Medical personnel do not have a duty to escape or to actively aid others in escaping as long as they are treated as retained personnel by the enemy.

e). If the captor does not permit medical personnel to perform their professional functions, they are considered identical to all other POWs with respect to their responsibilities under the Code of Conduct.

The situation may not be at all clear for the POW physician. The captor may allow the physician to provide medical care but might not provide the supplies necessary to do so. Perhaps the supplies are not available for the captor to distribute. It may be that medical provisions are being deliberately withheld as a means of reprisal or coercion. The captive must evaluate the situation and determine if circumstances warrant additional flexibility.

Article IV:

"If I become a prisoner of war, I will keep faith with my fellow prisoners. I will give no information or take part in any action which might be harmful to my comrades. if I am senior, I will take command. If not, I will obey the lawful orders of those appointed over me and will back them up in every way."

Comment: Medical personnel generally are prohibited from assuming command over non-medical personnel.

Article V:

"When questioned, should I become a prisoner of war, I am required to give name, rank, service number, and date of birth. I will evade

answering further questions to the utmost of my ability. I will make no oral or written statements disloyal to my country and its allies or harmful to their cause."

Comment: Medical personnel are required to communicate with a captor in connection with their professional responsibilities. Information regarding the number of sick, prevailing illnesses in the camp, needed medical supplies, and recommended public health initiatives should be conveyed to the captor. The captive physician should not provide personal information such as specifics about prior medical training, licensure, or practice. Communication should be limited to topics relating to POW health and welfare.

Article VI:

"I will never forget that I am an American, fighting for freedom, responsible for my actions, and dedicated to the principles which made my country free. I will trust in my God and in the United States of America."

Comment: No additional flexibility.

Conclusions:

POW treatment has followed an undulating course through history with gradual improvements interrupted by periods of regression. POW conditions are dependent on the cultural heritage of the detaining power, sensitivity to world opinion, political ideology, and socio-economic factors. These considerations influence the quality of quarters, food, medical care, clothing, and other humanitarian aspects of captivity.

Medical personnel who fell into the hands of the enemy were previously returned to friendly forces. In recent wars they have been detained by the captor for political, military, or economic reasons.[18] Captive American service personnel have never been treated in accordance with the Geneva Conventions. There is no reason to believe that this situation will change. It is probable that American POWs in future wars will be treated harshly, just as they have been in the past.

Any physician who is serving in the armed forces, whether active duty, Reserve, or National Guard, must realize that he (or she) could become a prisoner of war. Should the unthinkable occur, it is important to have reasonable expectations as to the conditions one might encounter during the period of captivity. It becomes the physician's duty to assert his rights under the Geneva Conventions, and to be willing at all times to perform his professional duties for the benefit of others in the POW community. If the physician is denied these rights, he assumes POW status and there is no longer any latitude with regard to the Code of Conduct.

The experiences of former medical POWs highlight a need for imparting to physicians a knowledge of medical history. This

knowledge may not have made life easier for past POW surgeons and physicians, but it might have at least helped them to realize that others have gone before and that they too can survive.[32]

In the past some have not been able to cope with the harsh realities of POW life. The very young, the elderly (in military terms), the fat, the unusually large, and the soft did not do well. Statistically, it is best to be in one's late twenties or early thirties, compact and in good shape, a non-smoker, to come from a small town, ranch or farm, and to be accustomed to hard physical labor. It is helpful to not be overly fastidious. Survivors need to be able to eat anything; those who could not force themselves to do so often died. In a world that is suddenly devoid of soap or hot water, the POW needs to be disciplined enough to wade through untold filth to get to the latrine, and then possess the prudence and care to clean himself as best he can afterwards.[32]

Dr. Rhonda Cornum, during her captivity in Iraq, maintained a courteous and professional demeanor with her captors which appeared to earn their respect, and undoubtedly was a favorable influence on her treatment as a captive.[7] Americans are often characterized as being arrogant and any hint of arrogance or superiority will be dealt with swiftly by a captor.

Every member of the armed forces should be certain that personal affairs are in order prior to deployment. The assurance that loved ones are provided for will spare the captive much mental anguish and unnecessary worry.

The prompt and safe return of prisoners of war has always been a high national priority. The captive physician must remember to keep faith with the other prisoners while awaiting repatriation. Trust that the U.S. will do all it can to secure the release of captured personnel at the earliest possible moment.

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